520-1
The Medi-Cal card shall be authorization for the person named on the card to receive those Medi-Cal services for which the person is eligible. (§50733(a))

520-2
Prior to 1994, all Medi-Cal beneficiaries received a paper Medi-Cal card for each month in which the beneficiary was eligible. In 1994, the Department of Health Services (DHS) began converting from paper Medi-Cal cards to the plastic Benefits Identification Card (BIC). Using the BIC, a provider can verify the beneficiary's Medi-Cal eligibility through the Point of Service (POS) Network. A new card is no longer issued to every Medi-Cal eligible person on a monthly basis. (All-County Welfare Directors Letter No. 96-06, February 1, 1996)

As of June 1, 1997, both Medi-Cal cards, and the Form MC-177, had been eliminated and had been replaced by the BIC system. (Denti-Cal Bulletin, Vol. 13, No. 13, June 1997)

521-1
The county department may issue current or past Medi-Cal cards, as limited by §50746, to all Medi-Cal eligibles who do not have a share of cost, who are not enrolled in a comprehensive Pre-paid Health Plan for which a card is requested, and who did not receive a Medi-Cal card. (§50743)

521-2
Prior to 1994, all Medi-Cal beneficiaries received a paper Medi-Cal card for each month in which the beneficiary was eligible. In 1994, the Department of Health Services (DHS) began converting from paper Medi-Cal cards to the plastic Benefits Identification Card (BIC). Using the BIC, a provider can verify the beneficiary's Medi-Cal eligibility through the Point of Service (POS) Network. A new card is no longer issued to every Medi-Cal eligible person on a monthly basis. (All-County Welfare Directors Letter No. 96-06, February 1, 1996)

As of June 1, 1997, both Medi-Cal cards, and the Form MC-177, had been eliminated and had been replaced by the BIC system. (Denti-Cal Bulletin, Vol. 13, No. 13, June 1997)

522-1
The county department shall not provide a Medi-Cal card or request that a Medi-Cal card be issued by the Department to any Medi-Cal beneficiary more than one year subsequent to the month of service, unless one of the following conditions is met:

(1) A court action requires that a Medi-Cal card be issued.

(2) An adopted state hearing decision or other administrative hearing decision requires a redetermination of eligibility which results in the beneficiary's entitlement to a Medi-Cal card.

(3) An adopted state hearing decision states that, due to county department or Department administrative error, a Medi-Cal card for a month was not received by the beneficiary.

(4) The Department requests that the Medi-Cal card be issued.

(5) The county department determines that an administrative error has occurred.

(§50746(a))

522-2
For purposes of issuing a Medi-Cal card more than one year subsequent to the month of service, a county administrative error shall include, but is not limited to:

1. The County Welfare Department failed to approve a Medi-Cal application by a potentially eligible individual due to legitimate errors made in the course of determining eligibility (e.g., an applicant was incorrectly denied and did not file an appeal, or an applicant's file was misplaced so eligibility was never determined).

2. The county or MEDS system showed an incorrect beneficiary address for the month of request.

3. The county never sent the original MC 177 to the State, or the original MC 177 is still in the case file after being returned by the State for the county to correct.

4. The county issued a card within one year but it was coded incorrectly and could not be used to bill for the services rendered.

(Medical Eligibility Manual, Procedures Section 14E-1, as set forth in All-County Welfare Directors Letter No. 94-77, October 11, 1994, interpreting §50746)

522-3
When an applicant has excess resources, counties must still complete eligibility determinations within the time limits set forth in §50177. If the applicant provides verification at a later date that excess property was spent on qualified medical expenses (up to three years from the date of the Notice of Action denying benefits), the county must rescind the denial if the applicant is otherwise eligible.

When billing may occur more than one year beyond the date of the service, the county shall complete and send a letter of authorization (MC 180) following the procedures in Medi-Cal Eligibility Procedures Manual §14E and §50746, and shall indicate that eligibility is granted as a result of court order (*Principe* v. *Belshé*).

(All-County Welfare Directors Letter No. 97-41, October 24, 1997)

522-4
Prior to 1994, all Medi-Cal beneficiaries received a paper Medi-Cal card for each month in which the beneficiary was eligible. In 1994, the Department of Health Services (DHS) began converting from paper Medi-Cal cards to the plastic Benefits Identification Card (BIC). Using the BIC, a provider can verify the beneficiary's Medi-Cal eligibility through the Point of Service (POS) Network. A new card is no longer issued to every Medi-Cal eligible person on a monthly basis. (All-County Welfare Directors Letter No. 96-06, February 1, 1996)

As of June 1, 1997, both Medi-Cal cards, and the Form MC-177, had been eliminated and had been replaced by the BIC system. (Denti-Cal Bulletin, Vol. 13, No. 13, June 1997)

For purposes of determining whether to issue a Medi-Cal card [which card no longer exists] more than one year subsequent to the month of service, and no administrative error exists, but extenuating circumstances exist beyond the beneficiary's or the county's control, the county may contact the Medi-Cal Eligibility Branch for assistance. Billing problems are not by themselves considered an extenuating circumstance. Furthermore, beneficiaries who are sent to collections after providing a Medi-Cal card should be told that W&IC §14019.4 precludes a provider from billing the beneficiaries in these situations.

An example of extenuating circumstances beyond a beneficiary's control would be a medical condition that severely impaired his/her functioning. Additionally, the beneficiary would need to describe how this reduced function prevented him/her from giving the provider(s) the necessary documentation of his/her Medi-Cal eligibility.

The Medi-Cal Eligibility Branch will evaluate whether a Letter of Authorization (LOA)/MC 180 can be issued pursuant to §50746(a)(4), which provides for an LOA/MC 180 to be issued by DHS request. The procedure to seek DHS authorization for issuance in these cases is as follows:

> The request must be in writing on county letterhead.

> It must list chronologically the sequence of events in the processing of the case and the circumstances surrounding the error.

> It must carry the original signature of a County Welfare Department Director or his/her DHS-approved designee (photocopied signatures will not be accepted).

> The request must be accompanied by an original LOA/MC 180 for each provider. However, in the event that one provider is billing for services for more than one month, one original LOA/MC 180 is sufficient.

> To insure proper use of this form, please cross out any months/years that are not being requested or not being used on the LOA for Medi-Cal billings.

(Medi-Cal Eligibility Procedures Manual §14E-2, 3)

523-1
A beneficiary who has been determined by the Department to be misusing or abusing Medi-Cal benefits by obtaining drugs or other services at a frequency or amount not medically necessary may be subjected to utilization restrictions in any of the following forms:

(1) Prior authorization for all Medi-Cal services.

(2) Prior authorization for specific Medi-Cal services.

(3) Restriction to utilization of a specific, beneficiary-or Department-selected pharmacy.

(4) Restriction to a specific beneficiary- or Department-selected primary provider of medical services.

(§50793(a))

The restriction described in (a) shall be for a period of two years from the effective date on the Notice of Action. (§50793(d))

523-2
If the beneficiary who has been determined to have abused or misused Medi-Cal benefits requests a hearing and the request is received prior to the effective date of the action, the action will not be taken until the hearing has been held and a final decision rendered. (§50793(f))

When the request is received on or after the effective date of the action, the action will remain in full force and effect pending a decision. (§50793(g))

523-3
Prescribed drugs shall be limited to no more than six per month unless: Prior authorization is obtained; the beneficiary is receiving care in a nursing facility; or the drugs are prescribed for family planning. (Welfare and Institutions Code (W&IC) §14133.22)

526-1
The Form MC 177S is used for the purpose of enabling beneficiaries to establish that they have met the Medi-Cal share of cost. The beneficiary is to present this form to providers of medical services. The provider is to list the cost and indicate the amount billed to the beneficiary. When the amount billed equals or exceeds the share of cost, the beneficiary shall return the form to the county and verify that he or she has assumed legal responsibility for the amount shown in the billed patient column of the form. The health services which can be used for the purpose of meeting the share of cost do not necessarily

have to be within the Medi-Cal scope of benefits but they must be provided by a Medi-Cal provider or any licensed practitioner meeting the criteria of a Medi-Cal provider. (§50657)

526-2
To meet the SOC, the provider of services will certify that payment for services will be sought from the patient and not from the Medi-Cal Program or a third-party insurer. (§50657(a)(6))

526-3
Retroactive adjustment of the SOC would be appropriate in situations where eligibility for a deduction is determined at a later date. (Medi-Cal Eligibility Procedures Manual §12 C)

526-4
When a person retroactively establishes property eligibility, under *Principe* v. *Belshé*, none of the medical expenses paid with otherwise excess property in order to establish eligibility shall be used to meet the applicant's SOC, nor applied to the SOC under *Hunt* v. *Kizer*. (All-County Welfare Directors Letter No. 97-41, October 24, 1997)

526-4A
In 1994, the Department of Health Services began converting from paper Medi-Cal Cards, issued monthly, to the plastic Benefits Identification Card (BIC). A new card is no longer issued to every Medi-Cal eligible person on a monthly basis. (All-County Welfare Directors Letter (ACWDL) No. 96-06, February 1, 1996)

As of July 1, 2003, there has been no change to §§50653.3 and 50657 which speak of the Form MC 177S and Medi-Cal cards, and there is no ACWDL nor MEPM revision which reflects the use of BICs. It should be noted, however, that effective June 1, 1997, paper Medi-Cal identification cards and the Medi-Cal share of cost MC-177 form were eliminated. Providers in all counties statewide use the plastic Benefits Identification cards (BICs) referenced in ACWDL No. 96-06.

(Denti-Cal Bulletin, Vol. 13, No. 13, June 1997)